

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 025030	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/29/2016
NAME OF PROVIDER OR SUPPLIER PROVIDENCE KODIAK ISLAND MED LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 1915 E REZANOF DRIVE KODIAK, AK 99615		
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F 000	INITIAL COMMENTS The following deficiencies were noted during an unannounced recertification Medicare/Medicaid survey conducted 1/26-29/16. The sample size included 7 active residents and 1 closed record. State of Alaska Department of Health and Social Services Division of Health Care Services Health Facilities Licensing and Certification 4501 Business Park Blvd., Ste. 24, Bldg. L Anchorage, Alaska 99503	F 000			
F 156 SS=F	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers	F 156		3/11/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

02/21/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 156	<p>Continued From page 1</p> <p>and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification</p>	F 156			

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F 156	<p>Continued From page 2</p> <p>agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>. Based on observation, interview and record review the facility failed to ensure all advocacy agency information was visibly posted in an area easily accessible to all residents and/or interested parties and had provided information about the residents' right to file a complaint with these agencies. This failed practice denied all residents (census of 20) and/or interested parties access to information on how to contact state agencies. Findings:</p> <p>Observation of the Fireweed and Salmonberry units from 1/26-28/16 revealed an 8.5 by 11 inch paper displaying the State Ombudsman's Office and Health Facilities Licensing and Certification contact information, in small print, located on the wall approximately 4 to 5 feet from the floor (near</p>	F 156	<p>Resubmitted 2/24/16 capturing following requested data to alleviate rejection of PoC: Clarify wording regarding signage posted for wheelchair bound residents. Location, height? and indicate the size of document, font size and exact location in the room for the ombudsman document.</p> <p>The advocacy agencies contact information has been posted in each home in an area that is easily accessible to wheelchair bound residents. The signage is 8.5"x 11" letter size; narrow margins; Arial Font, Size 18; placed by the side of the entrance/exit of each home</p>		

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F 156	<p>Continued From page 3 nurses station).</p> <p>During a group interview on 1/27/16 at 1:00 pm Resident #s 2, 3 and 9 did not know about the State Agencies' contact information or the location of its display on each unit. All three Residents were using a wheelchair for locomotion on the unit. In addition, Resident #'s 3 and 9 requested the information be placed in their rooms for easier access and readability.</p> <p>During an interview on 1/27/16 at 1:55 pm LN #3 stated the State Agencies' contact information was displayed "too high off the floor and in small print."</p> <p>Review on 1/28/16 of the facility's "Resident's Bill of Rights" in the admission packet, no date, revealed it did not contain phone numbers for Health Facilities Licensing and Certification department, Adult Protective Services, Medicaid Fraud unit, State Long Term Care Ombudsman or other advocacy agencies.</p> <p>During an interview on 1/28/16 at 7:38 am the Director of Nursing (DON) confirmed that the State Agencies' contact information was not presently in the admission packet. In addition, the DON confirmed the current posting of the agencies' contact information was too small and located too high.</p>	F 156	<p>next to the handicap push button and above the rails. The height measurement floor to top of document was approx. 4Ft. The accessibility and visibility/readability have been verified by a wheelchair bound resident in each home. A visually challenged resident was able to read without difficulty.</p> <p>The current display will remain intact for easy visualization/access for those not in a wheelchair. The area in front of the display is clear to assure easy access for walking residents. Each resident's room is furnished with a copy of the role of the ombudsman and the contact information. The resident's rights document has been updated with a revised date of 2/19/16 in the document. The update also includes advocacy agency contact information for Health Facilities Licensing and Certification department, Adult Protective Services, Medicaid Fraud Unit, the Office of the Long Term Care Ombudsman and the Disability Law Center of Alaska with a statement notifying the resident of their right to file a complaint with these agencies. Each current resident and/or POA and all new resident admissions will receive the updated resident right's document that will require signature attestation from the resident or POA validating written and verbal information received and understood on admission and annually. The resident handbook will be updated as well to include the revised dated resident rights, state advocacy agency contact information and information about the role of the</p>		

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F 156	Continued From page 4	F 156	<p>Ombudsman. Each resident room will be equipped with a packet including resident rights, facility contacts for concerns/grievances, state advocacy agency contact information, the document that contains the Ombudsman's information and stamped envelopes with paper and pen for private use in communicating with advocacy agencies. The packets will include documents that are 8.5" X 11" letter size; narrow margins. Arial Font; Size 18. The Font will be increased in size if necessary to accommodate residents with visual deficits. Also magnifying paper covers will be secured to allow easier readability if an elder has visual deficits. The packets will be located in the bedside table to start but where the resident chooses to keep them will be their own to decide once they move in. Residents will be additionally educated upon receipt of the packet in room.</p> <p>Resident Council Meeting was held as scheduled on 2/11/16. This meeting included resident education on state advocacy agency information by Social Worker.</p> <p>A second resident council meeting was held 2/17/16 with the Social Worker and Director. All residents were invited with seven residents choosing to participate. During this meeting, the residents were educated on the following:</p> <ol style="list-style-type: none"> 1. The role of the Social Worker and Director in managing their concerns and grievances; 		

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F 156	Continued From page 5	F 156	<p>2. The roles of the state advocacy agencies including the resident's right to contact state advocacy agencies at any time if they have a concern;</p> <p>3. The location of the state advocacy agency contact information in their room and on the unit</p> <p>On 2/15/16, the availability of the state advocacy agency information was shared at the family council meeting and written contact information will be attached to meeting minutes sent to all family members by Director or designee. (Minutes are normally completed by Family council president but she was not in attendance and families in attendance requested minutes from Director). State advocacy agency contact information location and updates have been added to the agendas for the nurses and CNA staff meetings in March 2016. The state advocacy agency contact information will be added to the footer of resident council meeting minutes document as well as the admission, quarterly and annual MDS. The Ombudsman will be invited to introduce himself/herself telephonically or in person to resident council.</p> <p>Random audits will be conducted monthly X 3 months then every 6 months by the Director or designee validating resident understanding of rights related to state advocacy agencies, the accessibility of information on the unit and to review the presence and understanding of room packet including resident rights, facility contacts for concerns/grievances, state</p>		

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F 156	Continued From page 6	F 156			
F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review the facility failed to provide care and services in a manner to maintain and promote dignity in the areas of dining. Specifically, by not providing the assistive devices needed to maintain dignity during independent dining for 1 sampled resident (#2) for a built-up spoon and 2 un-sampled resident's (#s 12 and 19) of 4 residents who required special plates. The manner and atmosphere in which independent residents dine can potentially affect their intake of nourishment and the respect and quality of life they deserve. Findings:</p> <p>Scoop Plate:</p> <p>Scoop plate is a dinner plate designed to help scoop food onto utensil by providing one edge of the plate that is higher than the other.</p> <p>Observation on 1/26/16 at 12:02 pm revealed</p>	F 241	<p>advocacy agency contact information, and stamped envelopes with paper and pen for private use in communicating with advocacy agencies. Also will review resident council meeting minutes.</p> <p>**Resubmitted as is per directives from Matthew L. Thomas, Health and Life Safety Code Surveyor on 2/24/16</p> <p>Seven residents who utilize adaptive equipment were assessed by the Occupational Therapist (OT) with the restorative aid (RA) during meal time reviewing proper use and efficacy of use with adaptive equipment for eating/drinking on 2/17/16 and 2/18/16. OT will continue practice of evaluating residents on admission, annually and when change in activity of daily living (ADL) status is appreciated. The Restorative Aid (RA) was provided education during these assessments on 2/17/16 and 2/18/16 as the RA attends meal time and is able to educate staff if utensils, plates, and cups are being use improperly. She is also able to identify</p>	3/11/16	

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F 241	<p>Continued From page 7</p> <p>Resident #19 at the dining table with his/her food on a scoop plate. The plate was positioned with the higher side facing away from the resident. During the observations the Resident made several attempts to scoop food onto the spoon, resulting in the food being scooped off the low side of the plate onto the table and the clothing protector.</p> <p>Observation on 1/27/16 at 12:14 pm revealed Resident #12 at the dining table with his/her food on a scoop plate. The plate was positioned with the higher side facing away from the resident. During the observations the Resident made several attempts to scoop food onto the spoon, resulting in the food being scooped off the low side of the plate onto the table and the clothing protector.</p> <p>During an interview on 1/27/16 at 3:00 pm during the change of shift report with both the day and evening CNA's were asked how to place a scoop plate in front of a resident. Several of the CNA's did not respond and those that did were aware the high edge is to face the resident.</p> <p>Weighted spoons:</p> <p>Observation on 1/27/16 from 8:30 am - 8:35 am, revealed Resident #2 was provided a non-weighted spoon to eat cereal and bananas with milk. During the observation the Resident made several failed attempts to bring the cereal from the bowl to his/her mouth resulting in food falling on the table and lap. In addition, the Resident was observed being shaky and dropped the spoon during the meal.</p> <p>Observation on 1/27/16 at 11:54 am revealed</p>	F 241	<p>changes that warrant a closer assessment by OT for adaptive feeding equipment. The seven resident care plans will be reviewed and updated by MDS nurse or designee to verify adaptive equipment use is reflected accurately. Focused hands-on CNA training will be provided at staff meeting in March regarding proper use of adaptive equipment for eating/drinking by OT.</p> <p>Nurses and CNAs will be provided with additional education regarding proper functional use of adaptive equipment for eating and drinking to maintain resident dignity and preserve independence as well as when to seek an Occupational Therapy evaluation for adaptive equipment in relationship to the functional tasks of eating and drinking. Measures in place to avoid recurrence include educating CNAs on the proper functional use of adaptive equipment for eating/drinking and what activity indicates the possible need for an Occupational Therapy evaluation for adaptive feeding equipment on new hire orientation and the annual competency plan.</p> <p>Random auditing will occur by restorative aid and or/therapist monthly X 3 months then annually to assure resident dignity through proper use of adaptive equipment for eating/drinking, the CNAs understanding of functional use of adaptive equipment for eating/drinking and what activity indicates the possible need for an occupational therapy evaluation for adaptive feeding</p>		

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F 241	Continued From page 8 Resident #2 eating a banana split after lunch with a non-weighted spoon. During this same observation several spoonfuls of ice cream were dropped onto the table and the clothing protector. During an interview on 1/27/16 at 3:00 pm during the change of shift report with both the day and evening CNA's were asked if Resident # 2 was to have adaptive silverware for independent dining, and they said yes. Record review of Resident #2's most recent care plan dated 12/9/15 revealed "[Resident #2] is intermittently eating independently after setup assist. Continue to encourage. Adaptive silverware: gray handle."	F 241	equipment.		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to provide documentation of resolutions for grievances brought forth during 6 out of 12 months reviewed from the Resident Council meeting minutes for 3 non sampled residents (#s 9, 11 and 12) out of 12 residents that attended the group meetings. This failed practice had the	F 244	**Resubmitted as is per directives from Matthew L. Thomas, Health and Life Safety Code Surveyor on 2/24/16 A resident council meeting was held 2/17/16 with the Director and Social	3/11/16	

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F 244	<p>Continued From page 9</p> <p>potential to adversely affect residents' quality of life and denied the residents the right to have their grievances addressed. Findings:</p> <p>Record review from 1/27-29/16, of the "Resident Council Minutes," dated 3/12/15, 4/9/15, 5/14/15, 7/9/15, 8/13/15, 9/9/15, and 10/21/15, revealed the following:</p> <ul style="list-style-type: none"> · 3/12/15: Resident #11 state concerns about things falling apart because of low staffing. · 4/9/15: Resident #9 complained staff not providing a call light and an inability to see the clock in the room. · 5/14/15: Resident #9 stated concerns regarding peri-care and family visit dining set up on Fridays. · 7/9/15: Resident #11 stated concerns of being interrupted during activities and complained of another resident coming in his or her room. Resident #12 complained of staff telling him/her they didn't have time to assist because of low staffing on evening shifts. · 8/13/15: Resident #9 commented about no popcorn being provided on movie nights and wanted to ensure it was available for any day requested. · 9/9/15: Resident #9 wanted to play solitaire on a computer or board. A general statement was documented as the residents wanted to go to Rendezvous again or Powerhouse. · 10/21/15: Resident #9 wanted the beauticians to come to the Elder House to do hair. In addition, 	F 244	<p>Worker. All residents in the facility were invited with seven residents choosing to participate. Residents were educated on the role of the Social Worker and the Director in managing complaints and grievances. Residents were educated on state advocacy agency contact information, their roles and the resident's right to contact these state agencies with concerns. We discussed privacy offering a private, individualized venue for a discussion about grievances or an open forum. All seven residents preferred to discuss grievances reported during state survey January 2016 and to be educated about the facilities procedure for handling complaints and grievances as a group. All grievances reported during the state survey January 2016 were addressed at this Resident Council meeting. Staff education and interdisciplinary work to be accomplished in support of prompt, sustainable resolutions for grievances. All residents will be offered to have individual update on grievance process for current grievances and the resolutions. This will also be shared at the next resident council meeting in March.</p> <p>The grievance policy was reviewed and updated during survey. This policy will be further updated to include a resident handout about the facilities procedure for handling complaints and grievances. Each current resident and all new residents will receive this handout. This tool will be reviewed at least quarterly at resident council meetings as well as family council meetings. The resident council policy was</p>		

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F 244	<p>Continued From page 10</p> <p>Resident #9 stated he/she had concerns with the current toileting schedule and wanted more greens, cucumbers, tomatoes and ranch dressing. Resident #12 stated he/she doesn't like to be told the nurses "don't have time" to help because of staffing issues. In addition, Resident #12 stated that he/she didn't want to wheel in and out of the room for meals and activities; questioned the location of his/her smoked salmon; wanted more condiments available; and stated concerns with the phone system not working properly.</p> <p>During a group interview with the Surveyors on 1/27/16 at 1:00 pm, the resident's voiced concerns of staff not providing assistance because they were too busy.</p> <p>During an interview on 1/27/16 at 2:18 pm, the Social Worker (SW) stated concerns from Resident Council were processed and emailed to department heads depending on the nature of the concern. In addition, the SW was unable to provide any documentation of these concerns being addressed.</p> <p>During an interview on 1/27/16 at 3:00 pm Resident #3 stated concerns of staff not answering call lights.</p> <p>During an interview on 1/27/16 at 3:31 pm the Director of Nursing (DON) stated the SW was responsible for following up on the grievances provided by the Resident Council. The DON further stated the process needed to be changed.</p> <p>Review on 1/28/16 of the facility's "THE LONG TERM CARE CENTER RESIDENT'S BILL OF RIGHTS," no date, revealed "As a Resident, you</p>	F 244	<p>reviewed. Residents were informed that the complaints and grievances received at the Resident Council Meetings shall be followed up by Social Worker and/or the Director individually and as a group at the following month's resident council meeting. The Resident Council agenda and meeting minutes will include agenda items that address reviewing the process for complaints/grievance reporting, receiving complaints and recommendations and review of the follow-up from the previous resident council meeting. In addition to the resident council meeting, complaints expressed by individual residents or family members will be handled on a one-to-one basis and followed-up by Social Worker and/or the Director. Grievances, i.e., unresolved complaints will be referred to the Social Worker and/or the Director. All complaints and grievances reported will be documented on complaint or grievance form which include details of the report as well as the resolution achieved. Residents were informed of the plan for each resident room to be equipped with a packet including revised resident rights, facility contacts for concerns, state advocacay agency contact information and stamped envelopes, paper and pen for private use communicating with advocacy agencies. Elder House staff will be educated regading complaint and grievance reporting procedure at the next staff meeting. This education will be included in new hire packet as well as annual competency plan for staff.</p>		

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F 244	Continued From page 11 have the Right:...to be informed of the facility's grievance procedure for handling complaints related to your care and to express grievances." Review on 1/28/16 of the facility's policy "Resident Council for Long Term Care," effective date 2/23/15, revealed "The Social Worker will address any concerns/complaints via the Grievance procedure." Review on 1/28/16 of the facility's policy "Grievance for Long Term Care," effective date 2/23/15, revealed "...Complaints received at the Resident Council Meetings shall be recorded in the meeting minutes. Interventions shall be documented in the following month's meeting minutes after being reviewed at the meeting...The department head will investigate the grievance and complete and return the grievance form to the Social Worker within 5 working days of receiving it."	F 244	Random audits will be conducted by the Director or designee monthly X 3 months then every 6 months for quality assurance process improvement to review the grievances process, grievance follow-through including resident input and understanding of the grievance process and the available resources.		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's	F 279		3/11/16	

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F 279	<p>Continued From page 12</p> <p>highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>.</p> <p>Based on record review and interview the facility failed to develop a comprehensive care plan based on the minimum data set (MDS) admission assessment for 1 resident (#3) out of 7 sampled residents whose care plans were reviewed. Specifically, the care plan did not address behaviors. Without appropriate care plan interventions and coordination, the resident was at risk for not receiving the necessary and/or appropriate care and services to ensure optimal outcomes. Findings:</p> <p>Resident #3:</p> <p>Review of the most recent MDS comprehensive assessment, an admission assessment dated 7/7/15, revealed the Resident coded as having behaviors.</p> <p>Record review on 1/28/16 of Resident #3's "RESIDENT DAILY CARE PLAN," last reviewed 1/13/16, revealed no care area in place for the Resident's behaviors.</p> <p>Record review on 1/28/16 of Resident #3's "CNA ASSIGNMENT CARD," dated 1/13/16, revealed an area of "Behavior." Further review of the</p>	F 279	<p>**Resubmitted as is per directives from Matthew L. Thomas, Health and Life Safety Code Surveyor on 2/24/16</p> <p>The resident care plan and the CNA assignment card were updated with behaviors during the January 2016 survey visit. The behavior care plan was further updated on 2/17/16 to capture additional behaviors. Nurses were educated regarding the importance of complete documentation of behaviors and care planning for interventions to ensure optimal outcomes on 2/10/16. All care plans and CNA assignment cards will be reviewed for proper care planning of behaviors by the Social Worker or designee. During data review for monthly nursing summaries, the nurse will ensure the documentation of behaviors are captured in the care plan and on the CNA assignment card. Nurses will be educated regarding this process expectation at the next staff meeting.</p> <p>Education regarding the importance of</p>		

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F 279	Continued From page 13 document revealed no objectives, goals, interventions or outcomes for behaviors. Record review on 1/29/16 of Resident #3's "Care Conference..." dated 10/29/15, revealed "Behaviors/Emotional Patterns...Be specific on description of observed behaviors." Record review on 1/29/16 of Resident #3's "Care Conference..." dated 1/13/16, revealed "Behaviors/Emotional Patterns...Be specific on description of observed behaviors." During an interview on 1/28/16 at 8:00 am the Director of Nursing (DON) confirmed Resident #3 did have a history of behaviors. The DON reviewed the current care plan and confirmed no behavior care plan was in place. Review of the facility's policy "Resident Assessment and Care Plan," revised date 1/2016, revealed "Care Plan...The Comprehensive Care Plan will be generated from the MDS CAAS [care area assessments] as well as other identified problems...The Comprehensive Care Plan includes measurable objectives and timetables to meet a resident's...mental, and psychosocial needs as identified by a comprehensive assessment ...It is the facility's responsibility to provide necessary care and services to attain or maintain the highest practical physical, mental and psychosocial well-being; in accordance with the comprehensive assessment and plan of care."	F 279	complete documentation of behaviors and care planning for interventions to ensure optimal outcomes will be provided for nurses and CNAs at next staff meeting. Education will be provided for behavioral modification interventions and tools by mental health professional(s) over the next month. Social Worker and MDS coordinator will monitor and update resident care plan and the CNA Assignment card on admission, quarterly and annual assessment as well as with significant change in status. Random audits will be performed by MDS Coordinator or designee monthly X 3 months then quarterly assessing completion of behavioral component of the care plan.		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		3/11/16	

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F 323	<p>Continued From page 14</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, interview and record review the facility failed to ensure 2 electrical wash cloth heating units, located in an area accessible to residents, were maintained in a safe manner. This failed practice placed 2 residents with dementia (#s 4 and 10) out of 20 residents residing in the facility at immediate risk for serious injury from thermal burns.</p> <p>This deficient practice constituted Immediate Jeopardy (IJ) to the residents' health and safety. The facility was notified of the IJ on 1/28/16 at 1:05 pm. The immediacy was abated by the facility on 1/28/15 at 1:10 pm.</p> <p>Observation on 1/28/16 at 12:45 pm revealed electrical wash cloth heating units on both the Fireweed and Salmonberry units. The heating units were located on the open serving bar of the kitchenettes and contained several wet washcloths. The areas were accessible to the residents.</p> <p>The Surveyor opened the heating unit on Fireweed and inspected the inner functioning and felt the wash cloths. During the inspection the Surveyor had to quickly remove his/her hand due</p>	F 323	<p>The two electric washcloth heating units were removed from each house outside of the building during the survey on January 28, 2016. A comprehensive review and investigation was conducted for a replacement unit and it was determined that no further washcloth heating unit will be purchased. Traditional resident hand washing will occur at the sink or with a washcloth to clean face and hands before and after meal intake. Nurses and CNAs will be educated regarding plan at next staff meeting.</p> <p>Facility reviewed for other heating units. The blanket warmer heating unit was reviewed for safety. This unit is not accessible to residents. The unit will have a sticker on it revealing acceptable temperature ranges. A temperature log will be maintained to check unit daily to assure temperature is within range. If this unit is not functioning within the temperature range and adjustment is unsuccessful with temperature control then no blankets are to be removed or used on a resident; a "do not use" sign is to be attached to the unit and</p>		

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F 323	<p>Continued From page 15</p> <p>to the temperature of the inner liner and metal grating that housed the heated moist wash cloths.</p> <p>During an additional observation on 1/28/16 at 12:48 pm, a facility thermometer was obtained and the electrical wash cloth heating unit on Fireweed measured 151.3 degrees F (Fahrenheit).</p> <p>Resident #4:</p> <p>Record review on 1/26-29/16 revealed Resident #4 was admitted to the facility with a diagnosis of Alzheimer disease (disease that causes memory loss and impaired judgement). The Resident resided on Fireweed.</p> <p>Review of the most recent Minimum Data Set (MDS) comprehensive assessment, an annual assessment, dated 4/30/15, and the most recent quarterly assessment, dated 1/25/16, revealed both assessments coded the Resident as having: memory problems; disorganized thinking and wandering behaviors.</p> <p>Record review of Resident #4's "Daily Care Plan," revision 12/11/15, revealed the Resident needed supervision while ambulating.</p> <p>Random observations from 1/26-28/16 revealed Resident #4 displaying wandering behaviors and pacing around the unit without the accompaniment of staff or visitors. Additional observations revealed the unsupervised Resident picked up and moved objects near the electrical wash cloth heating unit.</p> <p>During an interview on 1/28/16 at 12:49 pm a family member of Resident #4 stated the wash</p>	F 323	<p>maintenance contact initiated to the Facilities Director or designee to evaluate unit for safety. Staff will be educated regarding temperature monitoring of the blanket warming unit and steps to take when temperature is out of range at next staff meeting. Audit will occur by the Director or designee to review temperature logs and the unit itself monthly to ensure resident safety in support of resident comfort and burn prevention.</p> <p>Weekly environmental safety rounds will be done in each home to assess for potential accident and hazards in the environment including but not limited to devices, and equipment taking into account the residents in each home who have cognitive challenges, non-purposeful mobility, dependence needs, visual and auditory challenges, etc. A tool will be created to capture this safety rounding to share with staff for education and as a resolution tracking sheet. This will be completed by the Director or designee. The Infection Prevention Coordinator or designee will join Director in weekly rounding for the first quarter then twice a month. The Quality Director or designee will join the Director and Infection Prevention Coordinator for safety rounds twice a month. When a safety issue is identified, the resident, staff and/or visitor safety will be assured, item moved or implementation started to remove threat and prevent injury or accident. The Director of facilities and/or Director of Quality will be consulted as needed for</p>		

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F 323	<p>Continued From page 16</p> <p>cloths are "hot" and he/she had to cool them down before giving it to Resident #4.</p> <p>Resident # 10:</p> <p>Record review on 1/26-29/16 revealed Resident #10 was admitted to the facility with a diagnosis of dementia (disease that causes memory loss and impaired judgement). The Resident resided on Salmonberry.</p> <p>Review of the most recent MDS comprehensive assessment, an annual assessment dated 10/29/15, and the most recent quarterly assessment, dated 8/3/15, revealed the Resident was coded as having cognitive impairment and required supervision.</p> <p>Review of Resident #10's "CNA Assignment Card," dated 10/27/15, revealed "Problem (Behavior): Identified wanderer..."</p> <p>Random observations from 1/26-28/16 revealed Resident #10 displaying wandering behaviors and pacing around the unit without the accompaniment of staff. The Resident stood next to the electrical wash cloth heating unit multiple times during the observations.</p> <p>Review of the facility's policy "Resident's Needing Assistance with Eating," revised 1/2016, revealed "...Use washcloth to clean face and hands. (Standard of care 905.003...)"</p> <p>During an interview on 1/28/15 at 1:00 pm CNA #6 stated the electrical wash cloth heating units were used to aide residents in washing their hands before and after meals. In addition, the CNA stated the wash cloths were extremely warm</p>	F 323	safety issues.		

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F 323	Continued From page 17 to the touch. During an interview on 1/28/16 at 4:00 pm the Director of Nursing (DON) stated the electrical wash cloth heating units have two settings: 1) low is 150 degrees F and 2) high is 175 degrees F. The DON further stated the devices were set on the low setting. Review of the facility's policy "Standard of Care," revised 1/2016, revealed "Before Meal Care: Respectfully offer Resident to wash hands...After Meal Care: Respectfully offer warm washcloth to clean hands and face." Review of the American Burn Association article "Scald Injury Prevention Educator's Guide," accessed on 2/3/16 at www.ameriburn.org, revealed "High risk groups...Older Adults...have thinner skin...can cause deeper burns with even brief exposure..."Additional review revealed "Time and Temperature Relationship to Severe Burns" can cause intense burns at 148 degrees F to 155 degrees F in 1-2 seconds. Review of the American Burn Association article"Scald Injury Prevention Educator's Guide,"accessed on 2/3/16 at www.ameriburn.org, revealed elderly people are considered a high risk group for burns. Additional review revealed "Special Care: Nursing Home...majority of residents in these facilities are older adults...with limited ability to recognize and avoid other burn injury hazards, administrators of these facilities must consider...burn prevention as part of their plan of care."	F 323			
F 371	483.35(i) FOOD PROCURE,	F 371		3/11/16	

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F 371	<p>Continued From page 19</p> <p>drinks for the residents. An additional observation at 8:20 am revealed CNA #4's hair was not completely covered by a hairnet.</p> <p>Observations of the lunch meals on 1/26-29/16 revealed food brought to the cottage on a cart in bulk serving containers. The cart was not taken into the kitchenette but remained in the dining area near the table. CNA #s (2, 3 and 5) and LN #1 proceeded to unwrap the food containers and individually serve the residents without prior hand hygiene or donning hair nets.</p> <p>During an interview on 1/27/16 at 10:23 am, CNA #1 stated staff was required to wear hairnets in the kitchenette while preparing and serving meals.</p> <p>During an interview with the Assistive Dietary Manager (ADM) on 1/28/16 at 3:20 pm when asked about procedures after opening boxes of cereal, she stated the spouts should be taped over and sealed shut after each use. The items should be dated. Community food and personal resident foods should not comeingle on the same shelf. The ADM further stated that once the food leaves the main kitchen, she does not monitor food handling in the cottage kitchens, but regardless, staff are required to wash hands and wear hairnets while plating/serving food.</p> <p>An observation on 1/27/16 at 12:20 pm revealed LN #1 assisted feeding a resident and then walked into the cottage kitchen area without washing hands or donning a hairnet to prepare individual meals. The LN was observed preparing drinks obtained from the refrigerator. Further observation revealed CNA #2 entered the dining area and began feeding his/herself and a</p>	F 371	<p>carts are to be taken into small kitchenette area and served from there not in resident dining areas.</p> <p>Staff education will be provided regarding competency for food storage, location of food cart for serving and infection control practices in the kitchen. The Infection Prevention Coordinator or designee will use a kitchen audit tool created to monitor infection control compliance with food storage, location of food cart for serving, hand washing and glove use between clean and dirty tasks, use of hair nets and other infection control practices in the kitchenettes monthly providing additional training as needed.</p>		

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F 371	Continued From page 20 resident simultaneously, without first washing hands. Review on 1/29/16 at 2:00 pm of the facility's policy "Food Storage-Nursing Units," last reviewed 3/2015 "Procedure...All foods must be dated, labeled, and discarded after 72 hours," and "Opened containers must be dated and sealed or covered during storage" and "All foods belonging to patients must be labeled with name, room number, and date." Review on 1/29/16 at 2:00 pm of the facility's policy "Hand Hygiene Guidelines For Nutrition Services Employees," revealed hand washing is indicated "when entering the kitchen area ...during food preparation ...after handling soiled equipment, dishes and utensils...after cleaning a food preparation area...after contact with soiled clothing (i.e., clothing protectors) and wash rags."	F 371			
F 441 SS=L	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective	F 441		3/11/16	

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F 441	<p>Continued From page 21 actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: . Based on observation and interview the facility failed to ensure staff followed accepted infection control practices in the areas of medication administration and in the cleaning of the medication refrigerator, used to store resident medications. These failed practices placed residents at risk for cross contamination and transmission of infection in a vulnerable population (based on a census of 20). Findings: This situation constituted an immediate jeopardy and was brought to the attention of the facility's administration on 1/28/16 at 1:05 pm. The</p>	F 441	<p>**Resubmitted as is per directives from Matthew L. Thomas, Health and Life Safety Code Surveyor on 2/24/16</p> <p>The medication refrigerator in question was removed from the patient area immediately on 1/28/16. A new refrigerator has been finalized for purchase and ordered on 2/17/16. Nursing staff will be educated to ensure acceptable infection control practices in the area of medication administration and proper use of gloves during medication</p>		

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F 441	<p>Continued From page 22</p> <p>immediate jeopardy was abated on 1/28/16 at 1:10 pm.</p> <p>Based on record review and interview the facility failed to operationalize an effective Infection Control Program (ICP). Specifically, the facility failed to: 1) report ongoing infection prevention surveillance; 2) trend surveillance data; and 3) develop actions plans for trends identified. Failure to maintain an effective ICP and antibiotic stewardship placed vulnerable residents at risk for infection transmission. Findings:</p> <p>Medication Administration and Storage:</p> <p>Observation on 1/27/16 from 8:30 am - 9:30 am during a medication administration, Licensed Nurse (LN) #2 moved a trash container that was located in front of the medication refrigerator by placing the four fingers on the inner rim and the thumb on the outside rim. The LN then proceeded to use his/her samed gloved hand to prepare a resident medications.</p> <p>During this same observation the LN, using the same one gloved hand, grabbed the door of the medication refrigerator rubbing his/her fingers across the gasket seal, opened the refrigerator door and removed medications.</p> <p>Further observation of the refrigerator gasket seal revealed it appeared cracked along the top of the refrigerator edge. A thick black sticky substance mixed with debris was encrusted within the gasket's seal crevices. The same black substance lined the four sides of the gasket seal along the edge which included the bottom edge. Another substance, which was sticky and pink, was noted within the same refrigerator gasket</p>	F 441	<p>delivery. This will also be added to new hire nursing orientation and annual nursing competency review. Pharmacy staff will be educated to ensure acceptable infection control practices with cleaning the medication refrigerator. This will also be added to pharmacy new hire orientation. A cleaning tool has been established for nurse's medication preparation area each shift. This tool includes an area to document monthly refrigerator cleaning which will be accomplished by the pharmacy staff. Housekeeping will clean nurses station daily. Audits will occur monthly X 3 months then quarterly by the Infection Prevention coordinator or designee to verify proper infection control is being practiced during medication administration, use of gloves, cleaning medication administration area including the refrigerated storage unit for medication (once it arrives).</p> <p>An infection control committee will be established and led by the Director and the Infection Prevention coordinator. This committee will review and revise the current infection control program to support a focus on identifying long-term care surveillance methodology concentrating on reporting activities that are essential to infection prevention and control in elder care. Plan to incorporate an antimicrobial stewardship program. A risk assessment has been completed and will be reviewed by the committee once assembled. A tool will be developed to track and develop action plans for trends</p>		

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F 441	<p>Continued From page 23</p> <p>seal and a thick white powdery substance coated the entire floor ledge inside the refrigerator.</p> <p>During the same observation of 1/27/16 from 8:30 am - 9:30 am LN #2, after touching the contaminated seal on the refrigerator with his/her gloved hand, prepped an oral syringe & mouthwash obtained from the PYXIS system (storage system used to stock medications). LN #2 did not remove the contaminated gloves or wash hands, before administering the medications to Resident # 12.</p> <p>During an interview on 1/28/16 at 11:02 am the DON (Director of Nursing) was asked who was responsible for cleaning the medication refrigerator. The DON stated the nurses were to clean it and they also were to keep a log of the cleaning; however, no log had been maintained.</p> <p>Observation on 1/28/16 from 11:02 am-12:30 pm revealed the Pharmacist opened the medication refrigerator and ran his bare hand along the refrigerator's gasket seal; wiped his bare hand along the floor of the refrigerator and showed the DON his hand was covered with white powder.</p> <p>The Pharmacist informed the DON the refrigerator was contaminated and the medications needed to be thrown away. The Pharmacist further stated the refrigerator was to be removed from service immediately.</p> <p>During an interview on 1/28/16 from 11:02 am-12:30 pm the Pharmacist instructed staff to discard the medications and had the refrigerator removed from the facility. In addition, the Pharmacist stated the refrigerator was bacteria ridden but was not sure if the black substance</p>	F 441	<p>identified. Each home will be separately reporting infections, monitoring employee health, documenting infection prevention to track and trend statistics into operational data for process improvement each month. This data will be captured on dashboards and meeting minutes facilitated and managed by quality team and Infection Prevention coordinator reporting updated data to the Director at least monthly. All meetings must utilize discussion and review of data with documentation in minutes of a formal motion to approve agenda, changes, action plans, etc. The Infection Prevention coordinator and quality representative will attend nursing and pharmacy meetings at least quarterly to review dashboards, provide surveillance results, review action plans and discuss methods to improve infection rates in each home. The Infection control plan including surveillance methodology, risk assessments, surveillance trends and action plans will be reviewed by the hospital infection prevention (IP)committee quarterly then annually by the Performance Improvement Committee (PIC). The Director and /or the Quality Director will complete monthly audits on the infection control plan evaluating the plans efficacy, the dashboards comprehensiveness and review of the action plans for appropriateness of trended data.</p>		

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F 441	<p>Continued From page 24</p> <p>was mold. The Pharmacist further stated he could not guarantee the safety of the refrigerator medications. During the same interview the DON stated multiple times the refrigerator had to be removed and the refrigerator should not have been in this kind of condition.</p> <p>Infection Control Program:</p> <p>Record review on 1/29/16 at 9:15 am of the Infection Prevention Committee minutes:</p> <p>Dated 2/25/15, revealed "Zero infection control deficiencies from CMS [Centers for Medicaid/Medicare Services]." No documentation of infection prevention surveillance discussion or of antibiotic review.</p> <p>Dated 5/20/15, revealed "Have had pneumonia and UTIs [urinary tract infections], however no trending." No documentation of antibiotic review.</p> <p>Dated 8/19/15; 10/20/15; and 12/11/15, revealed no infection surveillance discussion or antibiotic review.</p> <p>Further review of LTC [Long Term Care] dashboard report, provided by the Infection Preventionist on 1/29/16 at 10:15 am revealed, 2 urinary tract infections and 1 lower respiratory infection for the 1st quarter and 1 lower respiratory infection for 2nd quarter. No data had been documented for 3rd or 4th quarter.</p> <p>Review of the line list of antibiotics dispensed to LTC residents for 2015 revealed only 5 of the 21 residents treated for an infection either met the surveillance criteria for infection or had significant</p>	F 441			

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F 441	Continued From page 25 bacterial growth on culture. During an interview on 1/29/16 at 10:30 am the Infection Preventionist confirmed the infection committee minutes had no documentation of any action plans, and had no documentation and antibiotic concerns. Review of the Quality Data provided revealed no trending report of infections to the committee or action plans for the number antibiotics dispensed for residents who did not meet infection surveillance criteria. Review of the "2015 Chiniak Bay Elder House Infection Prevention Program Plan" revealed, "the principle functions include...to obtain and manage critical data and information, including surveillance for infections ..." The plan did not include trending of data to determine if an action plan was appropriate and did not include antimicrobial stewardship. During an interview on 1/29/16 at 10:45 am the Infection Preventionist stated she was new to the position, as of September 2015 and could not speak to the lack of data prior to that date.	F 441			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.	F 514		3/11/16	

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F 514	<p>Continued From page 26</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview the facility failed maintain an accurate and complete medical record for 1 resident (#3) out of 8 sampled residents whose medical records were reviewed. Specifically, the facility failed to document all behaviors. Inaccurate and incomplete medical records placed the resident at risk for inconsistencies in the care provided by all staff. Findings:</p> <p>Review of the most recent MDS comprehensive assessment, an admission assessment dated 7/7/15, revealed the Resident coded as having behaviors.</p> <p>Record review on 1/28/16 of the Resident's chart, from 6/30/15 to 1/28/16 revealed a nurse documented only one episode of behaviors on 1/12/16 at 5:33 pm.</p> <p>During an interview on 1/28/16 at 8:00 am the Director of Nursing (DON) stated the resident has had more than one episode of behaviors. The DON confirmed all episodes were not documented in the medical record.</p> <p>During an interview on 1/28/16 at 11:00 am LN #1</p>	F 514	<p>2/24/16: In response to 2/24/16 rejection of below PoC: On 1/28/16 0945 MDS nurse updated documentation with late entry regarding behavior on 1/4/16 for the resident effected during survey when deficiency was identified.</p> <p>On 2/10/16, the nursing staff were educated regarding the importance of complete documentation of behaviors in the medical record. During monthly nursing summary completion, the nurse will review the documented behaviors as well as the behavior care plan for discrepancy and accuracy. Education will be provided at nurses meeting regarding expected behavior monitoring process in conjunction with monthly nursing summaries in which each nurse is assigned. This assignment has been updated to reflect nurses assigned to current as well as new resident's for summary completion. Additional education will be provided by mental health provider(s) for the nurses and CNAs regarding documenting behaviors and behavioral modification tools capturing</p>		

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F 514	Continued From page 27 stated Resident #3 has had more than one episode of behaviors. In addition, The LN stated nurses should document all behaviors. Record review on 1/29/16 of Resident #3's "Care Conference..." dated 10/29/15 and 1/13/16, revealed "Behaviors/Emotional Patterns...Be specific on description of observed behaviors."	F 514	those behaviors that are difficult to document such as inappropriate sexual behavior and manipulation. Social Worker will monitor behavior documentation at admission, quarterly and annual assessment as well as with significant change in status. Social Worker will assess resident when report received on new, recurring or worsening behavior. She will also document any behaviors assessed and the outcome of evaluation. Random audit will occur monthly X 3 months then every quarter assessing completion of behavioral documentation in conjunction with the plan of care.		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.	F 520		3/11/16	

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F 520	<p>Continued From page 28</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review the facility failed to maintain an ongoing quality assessment and assurance committee (QAPI). Specifically, the facility failed to provide documentation of: 1) accurate falls data for the year; 2) accurate medication event; 3) action plans for selected quality initiatives for 2015. Without consistent data collection the committee is unable to monitor the severity of quality initiatives identified, develop action plans, and evaluate outcomes. As a result, systematic correction could not be achieved and maintained throughout the facility. Findings:</p> <p>Falls</p> <p>During an interview on 1/28/16 at 9:35 am LN #4 was asked if the facility maintained a fall log. He/she provided this Surveyor with a copy, from a notebook at the nurses' station and stated the charge nurse was to document all falls on the log in addition to other fall related documentation.</p> <p>Review of the fall log provided from the notebook from 2/1/15 - 11/25/15 revealed a fall total of 24.</p> <p>Review on 1/28/16 at 1:18 pm of the "Risk Review - Falls" excel sheets provided by the</p>	F 520	<p>The current quality improvement plan will be reviewed and revised to develop a correlating QAPI plan under the collaboration of the LTC Director and the Quality Director. The development of QAPI plan will include identifying goals, scope of the plan and how the plan will address clinical care, quality of life and resident choice. The Director will establish a quality assessment and assurance committee / workgroup (QAPI) that will report quarterly to Performance Improvement Committee (PIC) which is the QAPI steering committee. The roles and responsibility for the QAPI committee will be defined including the roles of the resident and family. The committee will determine tools for Director to report QAPI activities to the community advisory board, family council and resident council. The initial performance improvement projects will include identifying appropriate tools and process for tracking falls and medication events assuring accuracy and avoiding duplication in response to January 2016 survey. Nurses and CNAs will be educated when updated processes are identified in relationship to falls management and medication event management. Dashboards will be created by quality team for individual performance</p>		

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F 520	<p>Continued From page 29</p> <p>Director of Nursing, from August to December 2015, revealed a fall total of 46. No data from this reporting form was provided for falls from Jan - July, 2015.</p> <p>Review on 1/28/16 at 1:18 pm of the "LTC QI [long term care quality improvement] data June 2015" report on falls from January - June 2015 revealed a fall total of 13. No data was recorded for the remainder of the year.</p> <p>Record review of the falls on the "Elder House UOR [unusual occurrence report] breakdown for 2015" from January - June 2015, revealed a fall total of 18. The same time frame as the above report.</p> <p>Review of the "Long Term Care QI Plan Dashboard" revealed the data reported on falls to the committee was based on falls per 1000 resident days through August. No data for September - December 2015.</p> <p>Review of the "Elder House General Events Types UORs 2015" revealed the fall total for calendar year 2015, was 51.</p> <p>Medication Events</p> <p>Review of the "LTC QI data June 2015 medication events" data from January - June 2015, a total of 8 medication events were reported. No data collected or reported for July - December, 2015.</p>	F 520	<p>improvement projects and QAPI plan. The QAPI plan will be reviewed monthly by the quality assessment and assurance (QAPI) committee; quarterly by the Quality director or designee and presented annually at the Performance Improvement Committee (PIC) and the Process Improvement and Patient Safety Committee (PIPS). The Director and /or Quality Director or designee(s) will audit compliance monthly X 3 months then quarterly to ensure the QAPI plan has consistent data collected to monitor initiatives identified, assess the development of appropriate action plans and evaluate outcomes for selected quality initiatives, namely fall and medication event monitoring and reduction. This audit will be reported to PIC and PIPS.</p>		

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F 520	<p>Continued From page 30</p> <p>Review of the "Long Term Care QI Plan Dashboard" from January - July 2015 revealed 12 medication events. No data reported for August - December.</p> <p>Review of the "Elder House General Events Types UORs 2015" revealed a total of 26 medication errors had been reported for 2015.</p> <p>Further review on 1/29/16 of all the data and forms provided for the Quality program revealed the process for collection and reporting of data was not defined, consistent, or accurate. In addition, no action plan documentation was provided for the 5 targeted QAPI Initiatives.</p> <p>During an interview on 1/29/16 at 11:15 am the Quality Director stated she was new, as of September, and cannot speak to the data collection/reporting of QA data from the LTC prior to September.</p> <p>During a subsequent interview with the DON, she also is new, as of November and cannot speak to the process or data collection prior to that date.</p>	F 520		